

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028735

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4210

FILED AUG 14 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT
1			
23068			
3			
4 0			
5 1			
6			
7 0			
8 2			
9422.1			
10			
11			
12 90-0			
13			
BY AFFIDAVIT OF	POCSIK	MEDICAL CERTIFICATION	SHOULD READ
USE BLACK INK OR TYPEWRITER RIBBON			

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 43 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 428 So. Drury		d. STREET ADDRESS (If outside, give location) 428 So. Drury	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE W. WALDRIDGE		4. DATE OF DEATH Month Day Year JULY 24, 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-11-1873
9. AGE (last birthday) 90		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & laborer		10b. KIND OF BUSINESS OR INDUSTRY Security Stove Co.	
11. BIRTHPLACE (City and state or country) Benton County, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Simon Waldridge		13b. MOTHER'S MAIDEN NAME Samanatha Ellen Wilson	
14. NAME OF HUSBAND OR WIFE Winnie Waldridge		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Winnie Waldridge 428 So. Drury	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Decompensated myocarditis Atherosclerosis Interval between onset and death 10 min 8 yrs 15 yrs Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from 1951 to July, 1963 and last saw him alive on July 24, 1963 Death occurred at 11:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) J. Pocsik	22b. ADDRESS 6518 Indep. Ave.		22c. DATE SIGNED 7/26/63
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-27-1963	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City, town, or county) Independence, Missouri
24. FUNERAL DIRECTOR Muehlebach	ADDRESS 6800 Troost	25. DATE RECD. BY LOCAL REG. 7-26-63	26. REGISTRAR'S SIGNATURE OP with Long

(Licensed Embalmer's Statement on Reverse Side)

Dr. J. P. Davis, D.O.  
6518 Independence  
Ch 1-48620 -  
Tel - 7428 S. Maryland  
723-1737

108, 200 Will Sign

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert L. Landes

Licensed Embalmer No. 5103

P. O. Address K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.